Texas Department of Insurance
Fraud Unit
Annual Report to the Commissioner

December 2015

Texas Department of Insurance
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Contents

EXECUTIVE SUMMARY

Texas Insurance Code, Section 701.101, requires the Fraud Unit to annually report the number of completed cases and any recommendations for new regulatory or statutory responses to the types of fraudulent activities encountered by the unit to the insurance commissioner.

FY 2015 STATISTICS

- Fraud reports received – 13,513
- Cases opened for investigation - 380
- Matters referred for prosecution – 112 unique cases with 169 suspects
- Estimated amount of fraud identified in referred cases - $8.56 million
- Indictments or Information issued resulting from investigations - 151
- Judgments from cases referred - 93
- Fines assessed by courts on Fraud Unit cases – $61,050
- Restitution assessed by courts on Fraud Unit cases – $14.1 million
- Subpoenas issued – 322
- Public Information Act Requests – 137

NOTEWORTHY ACCOMPLISHMENTS

- Received 13,513 fraud reports, the highest number in the unit's history
- Obtained 93 convictions and orders for deferred adjudication from referrals to prosecutors
- Obtained $14.1 million in court-ordered restitution
- Gave 31 presentations to industry partners, law enforcement officials, and community groups
- Completed peace officer and attorney-mandated training
- Expanded Fraud Prosecutor program by adding a fraud prosecutor to Tarrant County and a second fraud prosecutor to Harris County

TOP ADJUDICATED CASES

This report summarizes 10 investigations that resulted in criminal prosecutions and convictions. The fraud schemes are associated with agent fraud, workers' compensation fraud, health care fraud, claimant fraud, and mortgage fraud.

LEGISLATIVE RECOMMENDATIONS

There are no recommendations for legislative changes in this report.

Fraud Unit Overview

The purpose of the Texas Department of Insurance (TDI) Fraud Unit is to enforce laws relating to fraudulent insurance acts.[1] The unit protects the public from economic harm by investigating criminal insurance fraud allegations. Responsibilities include receiving and reviewing fraud reports, initiating inquiries, and conducting investigations when evidence shows insurance fraud may have been or is being committed. The Fraud Unit actively seeks criminal indictments, makes arrests, and assists in prosecutions to deter insurance fraud in Texas.

The Fraud Unit includes investigators, management, fraud prosecutors, and administrative support. Investigative positions are staffed with commissioned peace officers and civilian investigators. The chief investigator supervises and directs all peace officers and coordinates and oversees all investigations conducted by the Fraud Unit.[2]

Fraud Unit Philosophy

- We practice the highest ethical standards of law enforcement.
- As peace officers, we promise to obey the oath of office and to adhere to the Law Enforcement Code of Ethics.
- All members of the unit conduct themselves according to the highest principles of their professions and in an exemplary manner.
- We protect and serve the people of Texas.
- We educate and assist the public, the insurance industry, and other law enforcement agencies in efforts to identify and combat insurance fraud through enforcement of applicable statutes.

Fraud Reporting

Insurance fraud is a significant problem in Texas. Since 1996, the Fraud Unit has tracked the number of fraud reports it receives. In fiscal year (FY) 2015, the Fraud Unit received a record high 13,513 reports. The unit strives to enhance its outreach and education initiatives to create awareness and emphasize the importance of reporting suspected fraudulent activity. During FY 2015, the Fraud Unit made 31 presentations to industry partners, law enforcement officials, and community groups concerning insurance fraud detection, reporting, and investigation.

The Fraud Unit receives fraud reports through several different methods and from many different entities, including insurance carriers, the National Insurance Crime Bureau (NICB), National Association of Insurance Commissioners (NAIC), consumers, and businesses.

The Fraud Unit encourages everyone to report suspected insurance fraud. Fraud report submissions may be made by email or phone, or by completing an online form at http://www.tdi.texas.gov/fraud/report.html. The unit maintains the Fraud Report Hotline, which allows people to report fraud by speaking to a Fraud Unit investigator.

[1] Texas Insurance Code, Section 701.101(a)
[2] Texas Insurance Code, Section 701.104(b)

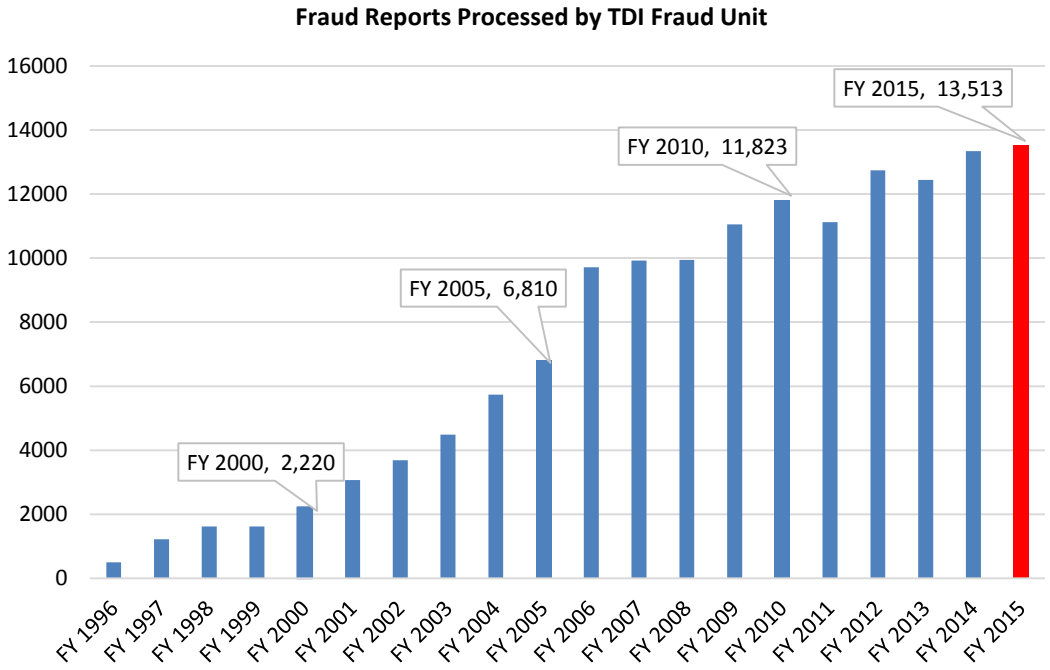


Figure 1: Fraud Reports Received since Inception of Fraud Unit

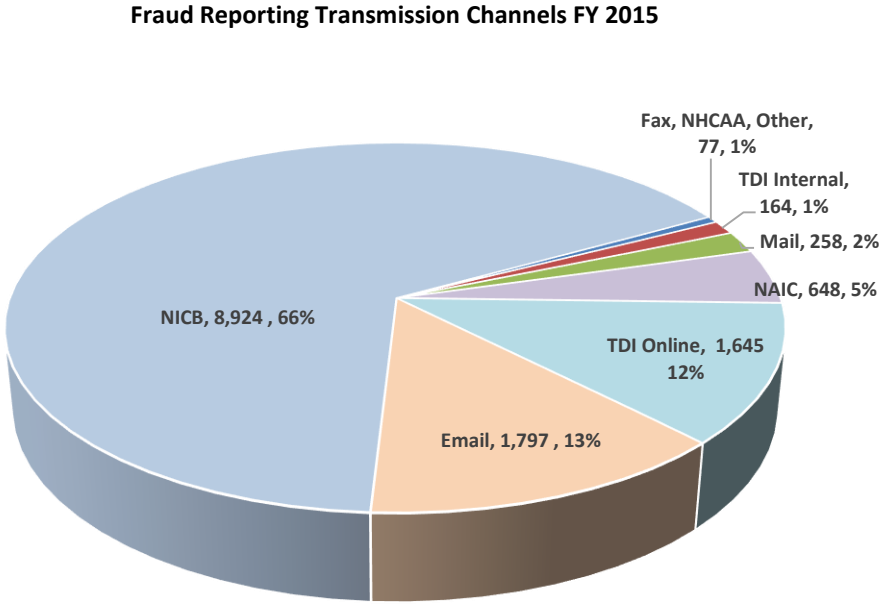


Figure 2: FY 2015 Fraud Reporting Transmission Channels

The table below represents the various fraud schemes documented during report processing.

Fraud Schemes	2013 (12,583 reports)	2014 (13,341 reports)	2015 (13,513 reports)
Adjuster Fraud	0.30%	0.26%	0.80%
Agent Conversion	1.03%	0.81%	0.56%
Agent Fraud	1.90%	1.72%	2.52%
Arson for Profit	1.40%	1.59%	1.25%
Auto Body Shop Fraud	0.69%	0.79%	0.81%
Auto Burglary	0.52%	0.50%	0.41%
Auto Theft	8.07%	7.32%	6.50%
Cargo Theft	0.06%	0.01%	0.15%
Company Employee Fraud	0.03%	0.07%	0.04%
Company Officer Fraud	0.11%	0.08%	0.12%
Disaster Adjuster Fraud	0.01%	0.00%	0.01%
Disaster Claim Fraud	0.02%	0.02%	0.25%
Discount Health Plan	0.00%	0.00%	0.00%
Escrow/Fee Attorney	0.00%	0.00%	0.01%
Extensive Loss History	0.64%	0.92%	0.61%
Faked Death	0.02%	0.02%	0.04%
Faked Injury	7.22%	7.81%	7.68%
False Billing	0.25%	0.51%	1.43%
False Claim Documents	15.87%	16.42%	21.15%
False Statements	13.18%	19.47%	17.81%
Fictitious Insurance Card	0.15%	0.19%	0.17%
Fictitious Insurance Certificate	0.20%	0.23%	0.19%
Hail Damage	4.49%	3.55%	3.34%
Identity Theft	0.33%	0.37%	0.53%
Inflated Claim	4.16%	3.64%	2.05%
Jump In	1.27%	1.09%	0.90%
Life Settlement Fraud	0.01%	0.00%	0.00%
Man-Made Roof Damage	1.07%	0.52%	0.39%
Medicaid Fraud	0.02%	0.01%	0.01%
Medicare Fraud	0.01%	0.01%	0.02%
Mold Claim	0.01%	0.00%	0.00%
Mortgage Fraud	0.23%	0.04%	0.04%
Organized Crime	0.46%	0.54%	0.48%
Owner Give Up	0.27%	0.31%	0.16%
Paper Accident	5.21%	3.73%	2.75%
Policy Application Fraud	7.32%	7.14%	6.76%
Premium Fraud	0.75%	0.79%	1.07%
Provider Billing Fraud	6.98%	4.98%	4.91%
Runner/Capper	0.52%	0.46%	0.42%
Slip & Fall	1.24%	1.33%	1.54%
Soft Tissue Injury	0.00%	0.03%	0.00%
Staged Accident	1.84%	1.49%	1.23%
Theft	7.90%	6.99%	6.80%
Theft from Elderly	0.03%	0.05%	0.04%
TPA Fraud	0.02%	0.02%	0.01%
Undetermined	1.54%	1.22%	0.78%
Unlicensed Agent	0.40%	0.23%	0.44%
Unlicensed Company	0.07%	0.13%	0.10%
Vendor Fraud	0.91%	1.27%	1.46%
Water Damage - HO	0.38%	0.56%	0.54%
Working & Drawing	0.82%	0.73%	0.70%

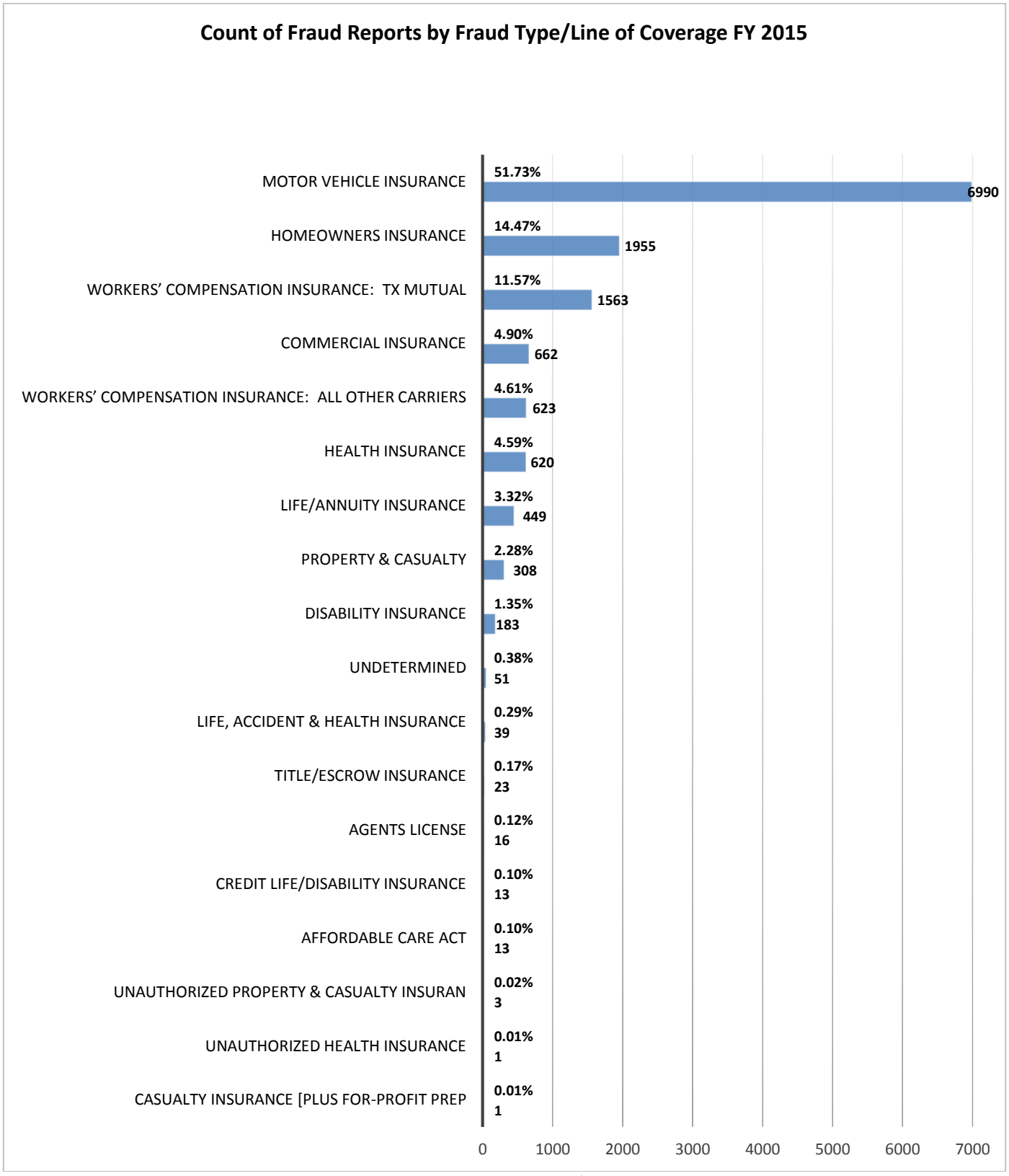


Figure 3: FY 2015 Fraud Reports by Type/Line of Coverage

In FY 2015, the unit opened 380 reports of fraud as investigations. The following table shows the number of reports received and cases opened by Fraud Type/Line of Coverage. Please note that the Travis County District Attorney has a special prosecutor that is assigned to handle workers' compensation fraud cases for a specific carrier according to a statutory provision.

Fraud Type/Line of Coverage	No. of reports received	No. of cases opened	Percentage opened as compared with number received
Agents License	16	2	12.5%
Casualty Insurance	1	1	100.0%
Commercial Insurance	662	34	5.1%
Disability Insurance	183	21	11.5%
Health Insurance	620	28	4.5%
Homeowners Insurance	1955	65	3.3%
Life, Accident & Health Insurance	39	6	15.4%
Life/Annuity Insurance	449	29	6.5%
Motor Vehicle Insurance	6990	114	1.6%
Property & Casualty	308	32	10.4%
Title/Escrow Insurance	23	4	17.4%
Unauthorized Property & Casualty Ins.	3	1	33.3%
Workers' Compensation Insurance, non-TX Mutual	623	43	6.9%

In FY 2015, the unit made 169 referrals to prosecutors. The following table shows the number of referrals by Fraud Type/Line of Coverage. The prior two fiscal years are provided for comparison.

Referral Fraud Type/Line of Coverage	FY 2013	FY 2014	FY 2015
Agents License	0	0	2
Credit Life/Disability Insurance	1	1	0
Commercial Insurance	10	9	10
Disability Insurance	13	16	8
Health Insurance	7	7	8
Homeowners Insurance	24	21	33
Life, Accident & Health Insurance	11	3	1
Life/Annuity Insurance	7	6	23
Motor Vehicle Insurance	85	98	67
Property & Casualty	9	9	10
Title/Escrow Insurance	40	4	0
Undetermined	1	0	0
Unauthorized Property & Casualty Insurance	0	1	0
Workers' Compensation Insurance	13	13	7

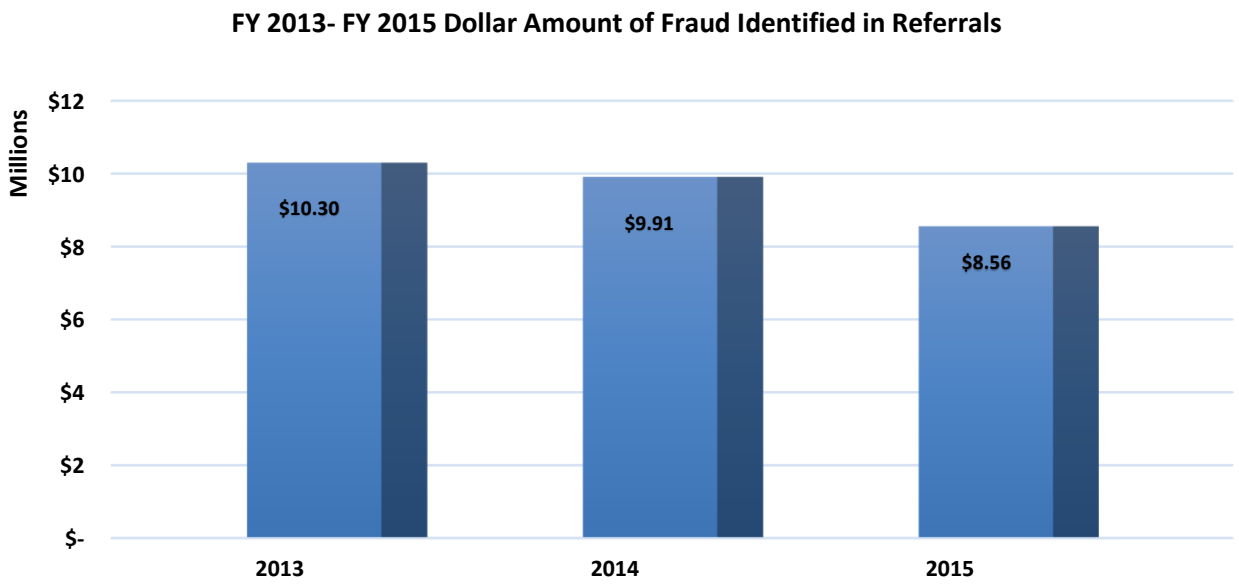


Figure 4: FY 2015 Dollar Amount Identified in Referrals

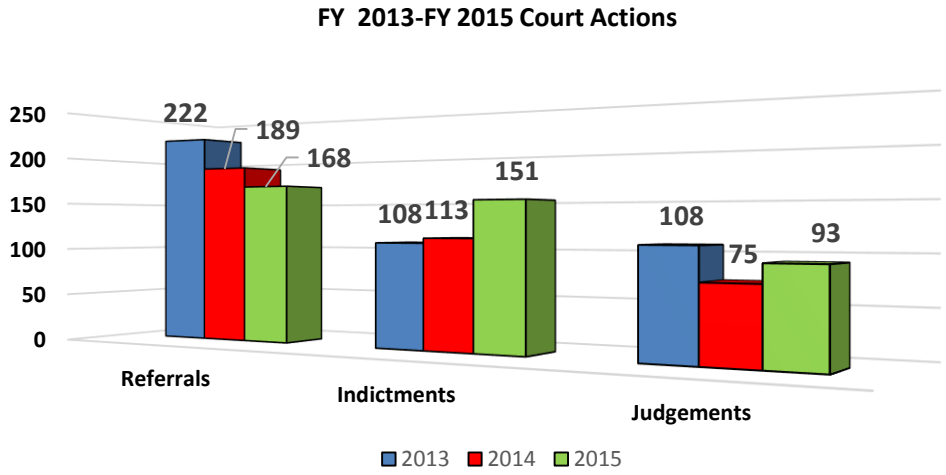
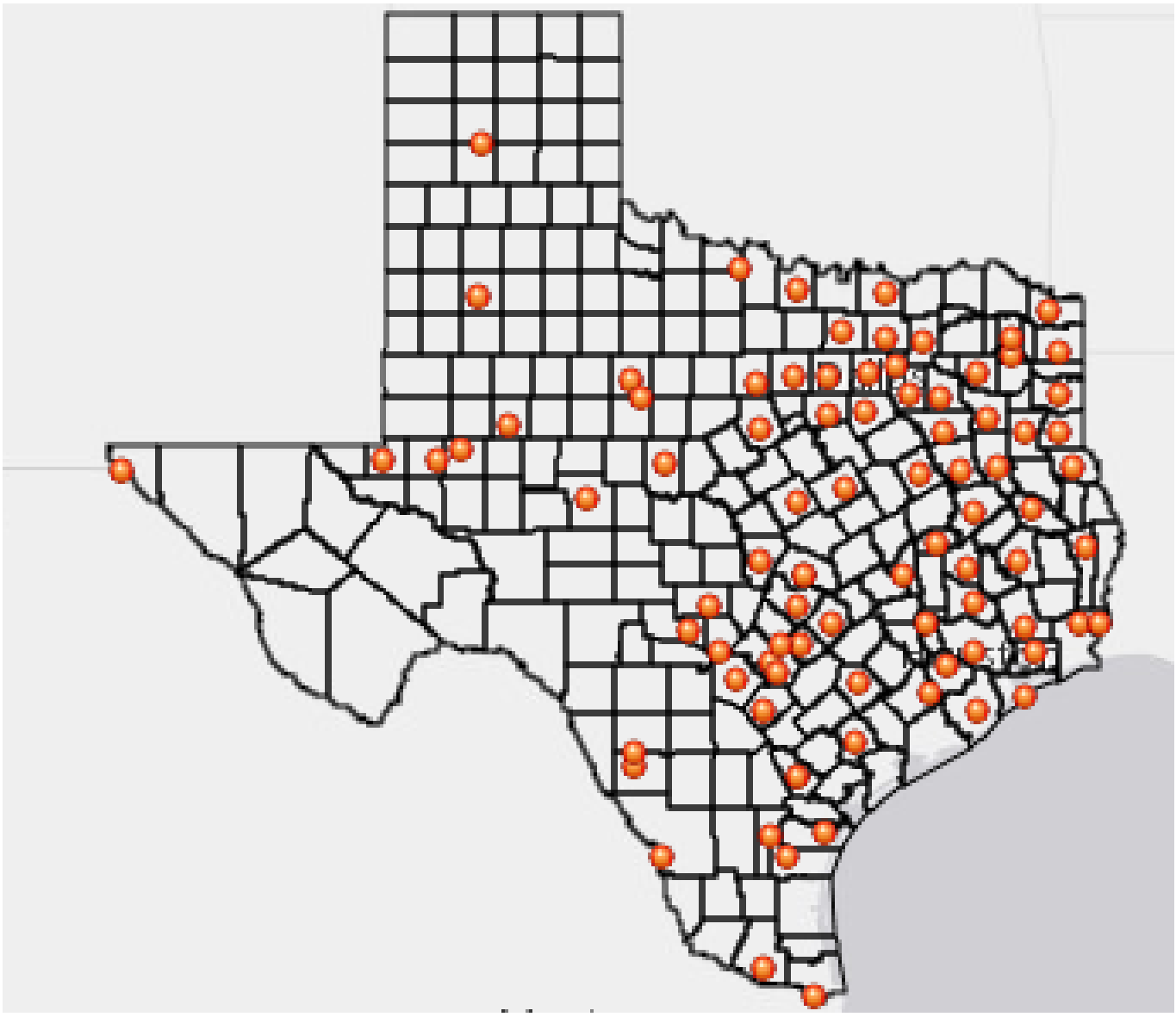


Figure 6: FY 2013-14 Court Actions

FRAUD UNIT CONTINUES TO REGIONALIZE INVESTIGATIVE FUNCTIONS

As the number of fraud reports continued to increase across the state, the Fraud Unit began placing investigators in field offices. While instances of fraud are traditionally associated with densely populated urban areas, reports have also been coming in from more geographically remote areas. By the end of FY 2015, there were 830 active investigations pending in 194 cities and 87 counties across the state. Another 16 active investigations involved eight other states. One investigation involved Barbados.

Active investigations map



Because of the widespread increase in activity, investigators are traveling more in the course of their daily activities. Because of the size of the state, some cases involve work that requires the investigator to travel for six to eight hours to reach the destination. This results in less time spent conducting investigations. It also results in additional costs for lodging, travel, and per diem expenses.

As a result, the unit is placing investigators in strategic locations throughout the state, rather than housing everyone in Austin. The unit has investigators in four cities outside of Austin, including Dallas, Fort Worth, Houston, and San Antonio.

In addition to reducing travel-related costs, this concept helps foster more relationships with fraud victims, as well as local law enforcement agencies that might not be as familiar with the intricacies of this type of financial crime. Local authorities have shown a great interest in developing working relationships with the unit.

Administrative Team

The dedication of the Administrative Support Section staff drives much of the success the Fraud Unit experiences as a whole. It is with this team that the entire investigative process begins.

Administrative team members review every incoming fraud report and start the data entry process. They compile information from the reports and provide it to management so managers can decide whether to proceed with a formal investigation. Once that determination has been made, all reports received are entered into the unit's case management system for future reference.

The administrative team researches investigative databases and files for any clues relevant to cases, and then provides findings to investigators for use in their investigation.

The team oversees open records requests, archived files, distributes and recovers supplies, processes travel requests, addresses personnel issues, tracks budgetary matters, processes subpoenas, maintains evidence, monitors referred case progress, and oversees scheduling for Fraud Unit management.

The team has one certified project manager who is often tasked with developing reports, charts, and graphs to illustrate the activities of the unit. In FY 2015, this person also oversaw the unit's efforts in building a new case management system that is expected to be operational in FY 2016.

The team also includes two criminal analysts who tackle the monumental task of entering and analyzing vast amounts of financial data into meaningful graphics that prosecutors use to illustrate the flow of money associated with various insurance fraud schemes. The criminal analysts also develop link charts to show the relationships between all parties involved.

Investigation Teams

An investigator's primary goal is resolving insurance fraud criminal allegations. While some investigations pertain to an isolated offense, others involve many suspects engaged in elaborate schemes to defraud countless victims.

The Insurer Fraud Section investigates fraud schemes involving insurance companies, agents, and other TDI licensees (including third-party administrators, escrow and title insurance companies, and agents), and eligible surplus lines insurers, as well as fraud schemes involving unlicensed insurance operations.

These investigations may involve securing the execution of documents by deception, misappropriation of fiduciary funds, and forgery.

The Claimant and Provider Fraud Section investigates various claim fraud schemes, such as inflated claims, false claims for property loss, staged accident rings, fake burglary claims, staged slip-and-fall cases, and other suspicious liability insurance claims. Investigators also examine reports of fraudulent billing by health care providers, as well as reports of unlicensed providers and fraud rings involving health insurance claimants, providers, and attorneys. Fraudulent billing may include instances of over-billing, double billing, and billing for procedures not performed. Investigators within the Claimant and Provider Fraud Section are also tasked with conducting investigations of major fraud allegations that involve complex transactions, significant losses, or both.

The Workers' Compensation Fraud Section investigates suspected workers' compensation fraud reports involving claimants, providers, and employers. Workers' compensation insurance fraud schemes may include a claimant receiving benefits while working at another full-time job, malingering, or may include a provider over-billing for services or billing for treatments never rendered. It may also include an employer who misrepresents payroll or employee classifications in the procurement of workers' compensation insurance.

While all investigations carry some commonality in the steps needed to prove or disprove the allegations at hand, the means and methods to resolve those allegations vary by type of offense. TDI works to maintain close contact with local, state, and federal law enforcement agencies, as well as industry partners and other TDI divisions. Investigators use the agency's subpoena authority given under TIC Section 701.106 to gather documentary evidence and conduct interviews with victims, witnesses, and suspects. Occasionally, investigators will conduct surveillance in order to locate a person of interest in a case.

Prosecution Team

The Fraud Unit has six dedicated prosecutors who are employed by TDI but are deputized as assistant district attorneys in Bexar, Dallas, Harris, and Tarrant County district attorneys' offices. This initiative began in 2005 through a memorandum of understanding with the Dallas County District Attorney's Office, and because it was very successful, TDI expanded the program to include Bexar and Harris counties in 2012 and Tarrant County in 2015.

The prosecutors work with TDI Fraud Unit peace officers, local, state, and federal law enforcement, and the insurance industry to effectively prosecute all types of insurance crimes.

TOP 10 ADJUDICATED CASES

1) In U.S. District Court-Northern District of Texas, Dr. Abbas Zahedi and Reginald Guy were found guilty by jury verdict of Conspiracy to Commit Health Care Fraud, Health Care Fraud, and Aggravated Identity Theft. Dr. James Sterns and Tina Perkins also pleaded guilty to Conspiracy to Make False Statements Relating to Health Care Matters. These proceedings arose from a joint investigation of Metroplex DFW Sports & Rehabilitation Clinic for submitting false claims for payment and falsely using doctors' signatures. The investigation was conducted by the TDI Fraud Unit and the Federal Bureau of Investigation. Perkins was sentenced to 10 months of incarceration followed by 36 months of supervised release. Guy was sentenced to 156 months of incarceration followed by 36 months of supervised release. Dr. Zahedi was sentenced to 145 months of incarceration followed by 36 months of supervised release. Dr. Sterns was sentenced to 10 months of incarceration followed by 36 months of supervised release. These four defendants, along with two additional co-defendants identified as a result of the investigation were ordered to pay $2.4 million in restitution.

2) In Harris County, Telly J. Smith pleaded guilty to first-degree felony Aggregated Theft. Smith created "Exodus Title Company," purportedly located in Tomball, Texas. He then convinced a mortgage lender to fund $3.2 million for three properties in Houston. Smith provided false and forged documents to convince the lender that he or his companies owned the three subject properties. In fact, he had no ownership interest in the properties or the various companies that actually owned the properties. Smith was sentenced to 55 years of incarceration in the Texas Department of Criminal Justice and ordered to pay a $10,000 fine, $239 in court costs, and $1.7 million in restitution.

3) In U.S. District Court-Eastern District of Texas, Patricia Hines and David Diggles pleaded guilty to Conspiracy to Commit Mail Fraud. Between December 16, 2005, and August 22, 2006, Hines and Diggles schemed to defraud numerous mortgage and investment lenders by fraudulently representing the purchase and subsequent sale of property in Dallas. This investigation was a joint effort between the TDI Fraud Unit and the Federal Bureau of Investigation. Hines was sentenced to 52 months of incarceration, three years of supervised release, and ordered to pay nearly $1.6 million in restitution. Diggles was sentenced to 97 months of incarceration in the U.S. Bureau of Prisons and ordered to pay $7.3 million in restitution.

4) In Wilson County, Patsy Ritchie pleaded guilty to third-degree felony Theft. Investigation by the TDI Fraud Unit revealed that Ritchey misappropriated more than $418,812 from seven victims. This money was given to her by the victims with the agreement that it was to be invested in an annuity. Among other fraudulent activities, Ritchey stole premiums, illegally withdrew cash from life insurance policies, created fictitious insurance policies, forged signatures, insured individuals without their knowledge, and employed individuals who were not licensed by TDI to conduct the business of insurance in Texas. Ritchie was sentenced to 10 years of incarceration in the Texas Department of Criminal Justice and ordered to pay $262 in court costs, and $89,836 in restitution.

5) In Harris County, Juan J. Perez pleaded guilty to second-degree felony Insurance Fraud. On or about August 24, 2012, in Houston, Perez reported that he accidently fell at his place of employment and collected workers' compensation benefits as a result. Perez admitted that his fall was staged and was not an accident. Indemnity payout by the workers' compensation carrier to Perez was $50,521 the medical payout totaled $125,563, and expenses incurred by the carrier for administering the claim totaled $48,722, all of which Perez was not legally entitled to receive. Perez was sentenced to two years of incarceration in the Texas Department of Criminal Justice and ordered to pay $234 in court costs and $176,084 in restitution.

6) In Dallas County, Melissa Kay Shook pleaded guilty to second-degree felony Fraudulent Use/Possession of Identifying Information. Shook, a contract sales agent for an insurance carrier, submitted 25 policy applications on eight different individuals within a single group of employees working for an employer. The employer's human resources department informed the carrier that the eight subjects that appeared on their monthly bill did not work at the company. Shook received $4,446 in advanced commissions based on the applications submitted to the carrier. All the applications used the employer's corporate name, but listed a fictitious address in the same city. The applications listed correct names of actual people, as well as correct dates of birth and Social Security numbers. However, the addresses and phone numbers listed for these applicants were fictitious. None of the named applicants authorized the use of their identifying information. Shook was sentenced to 10 years of probation and ordered to pay a $2,000 fine, $244 in court costs, and $65,538 in restitution.

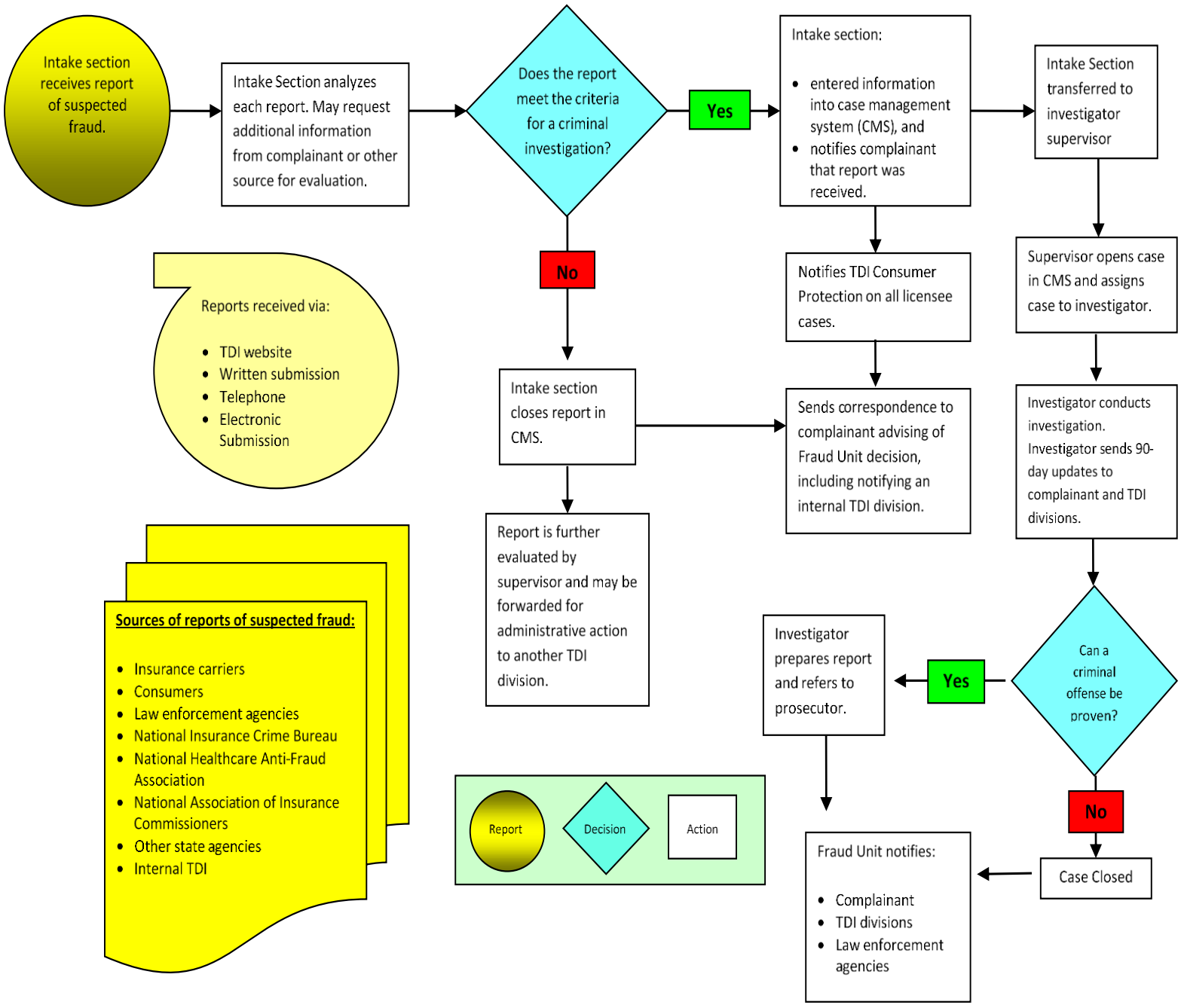
7) In Dallas County, Charles Ramey Falkner pleaded guilty to third-degree felony Insurance Fraud. On July 7, 2008, Falkner reported that he could no longer work and began receiving total disability income benefits from a workers' compensation insurance carrier. On January 19, 2010, Falkner failed to report that he had started working full-time for a new employer. From January 2010 to August 2011, Falkner submitted 17 "Requests for Continuance of Disability Benefits" forms to the workers' compensation carrier and made the continued material misrepresentation that he was not working. As a result, Falkner received $59,356 in total disability benefits that he was not entitled to. Falkner was sentenced to 10 years of probation and ordered to pay a fine of $2,500, court costs of $244, and $59,365 in restitution.

8) In Archer County, John Shoemaker pleaded guilty to first-degree felony Insurance Fraud. From June 2011 to February 2013, Shoemaker submitted payment requests to an insurance carrier for bogus supplemental work to be done on eight existing claims. Shoemaker prepared a statement that he knew contained false or misleading material information and presented it to the insurer. This resulted in the carrier issuing payments totaling $273,998 for supplemental work that was never done. Shoemaker was sentenced to 10 years of incarceration probated for a period of 10 years and ordered to pay $327 in court costs, and $50,000 in restitution.

9) In Lubbock County, Hector Villalobos pleaded guilty to third-degree felony Insurance Fraud and Isabel Jimenez pleaded guilty to state jail felony Insurance Fraud. Villalobos and Jimenez submitted multiple fraudulent short-term disability claims to an insurance carrier. The claims were filed for subjects purportedly employed at the same place and purchased as group short-term disability policies through the place of employment. The investigation revealed that, while each person received legitimate chiropractic and medical treatment, suspects added or altered return-to-work dates and disability dates prior to submission of claims. As a result of the fraudulent claims, the carrier paid $111,376. Villalobos was sentenced to five years of deferred adjudication with 160 hours of community service and ordered to pay $236 in court costs and $40,315 in restitution. Jimenez was sentenced to four years deferred adjudication with 120 hours of community service and ordered to pay $236 in court costs and $14,525 in restitution.

10) In Collin County, Antoinette Hayes pleaded guilty to first-degree felony Money Laundering. Hayes caused a mortgage lender to execute wire transfers affecting property in Collin County in the amount of $1.2 million with the intent to defraud the lender. The criminal proceeds of this loan were then invested by buying real estate to launder the proceeds from the initial criminal act. Hayes was sentenced to 10 years of incarceration probated for six years and ordered to pay court costs of $365.

PROCESS CHART



ORGANIZATIONAL CHART